



**DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH PROFESSIONAL LICENSING ADMINISTRATION  
BOARDS OF MEDICINE AND PHYSICIAN ASSISTANT**

**CHARACTER REFERENCE FORM**

\_\_\_\_\_  
APPLICANT'S NAME

\_\_\_\_\_  
APPLICANT'S ADDRESS

Dear Sir/Madam

The applicant whose name and address appear above has applied for a license to practice as a Physician Assistant in the District of Columbia and lists you as a reference for his/her moral character and professional experience.

Please complete and return this form to the address below. Your prompt attention to this request will greatly assist the Board of Physician Assistant when considering the applicant for licensure. The Board will consider your reply as confidential information.

**Department of Health  
Health Professional Licensing Administration  
Board of Physician Assistant  
717 - 14th St NW, Suite 600  
Washington, DC 20005**

TO: District of Columbia, Board of Physician Assistant.

I hereby certify that since (date)\_\_\_\_\_, I have been closely associated with  
\_\_\_\_\_, residing in  
\_\_\_\_\_ as to be able to intelligently express an  
opinion as to his/her character, mental condition and habits, and tat to the best of my knowledge  
and belief, he/she is of good moral character and free from mental defects and drug habits that  
are liable to interfere with the proper practice as a Physician Assistant.

REMARKS:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name (Please Print or Type)

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Address